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No. 88-1503

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
Petitioners,
v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,
v.

THAD C. MCCANSE, Guardian ad litem,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of the State of Missouri

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BRIEF OF AMERICAN ACADEMY OF NEUROLOGY AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION

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BRIEF OF AMERICAN ACADEMY OF NEUROLOGY AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION

INTEREST OF *AMICUS CURIAE*

The American Academy of Neurology (the "Academy") is a non-profit organization comprised of over 10,000 neurologists throughout the United States. Because the Missouri Supreme Court's 4-3 ruling in this case will significantly and adversely affect these physicians' medical practices, the Academy submits this brief on behalf of its members in support of the Petition for Writ of Cer-

tiorari. Letters from all parties to the case below indicating their consent to the filing of this brief have been filed with the Clerk of the Court.

Neurologists are called upon routinely to evaluate injuries to the brain and to advise patients and their families or guardians regarding appropriate medical treatment. Often, neurologists must decide swiftly in the early stages of treatment whether to recommend the use of artificial life support technologies to sustain bodily functions while they pursue specific treatment strategies. These decisions are made with the knowledge that such life support technologies can maintain a patient's bodily functions for many years after the treatment strategies have failed and the patient has permanently lost all consciousness. Because the ruling below renders the *initial* decision to employ life support *irrevocable* in many cases, the ruling interferes with neurologists' ability to recommend certain medical procedures and with patients' and their families' ability freely to give informed consent to such procedures.

The members of the Academy are particularly concerned about the implications of the decision below for the thousands of patients with the most severe form of neurologic disability, those in a "persistent vegetative state" ("PVS patients"). In an effort to provide medical and ethical guidance to doctors in this important area, the Academy has adopted a formal statement of policy regarding the treatment of such patients. *See* American Academy of Neurology, Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient (April 21, 1988), *reprinted in* Neurology, Jan. 1989, at 125 (hereinafter "Academy Statement") (Appendix A).

The Academy Statement reflects careful deliberation by the Academy after thorough review of medical, ethical, and legal literature, and the extensive clinical experience of Academy members with PVS patients and

their families. The Statement is founded on the accepted principle of medical ethics that neurologists, like all physicians, have a duty to promote aggressive treatment of unconscious patients for so long as hope of recovery remains. The corollary principle mandates that when hope is gone, sound medical ethics permit neurologists to terminate all treatment, including artificial nutrition and hydration, if desired by their patients or the patients' legal representatives. Neurologists have a strong interest in practicing medicine in a manner consistent with their code of ethics, an interest severely compromised by the ruling below.

On behalf of its member neurologists, and on the basis of its stated interests, the Academy urges this Court to grant certiorari in this critically important case.

ARGUMENT

I. THE DECISION BELOW RAISES ISSUES OF CRITICAL NATIONAL IMPORTANCE BECAUSE IT INTERFERES WITH PHYSICIANS' ABILITY TO CARE AGGRESSIVELY FOR UNCONSCIOUS PATIENTS WHILE HOPE OF RECOVERY REMAINS AND REQUIRES CONTINUED TREATMENT AFTER HOPE NO LONGER REMAINS

A. The Persistent Vegetative State Patient and the Importance of the Decision Below

It is estimated that more than 10,000 patients—like Nancy Cruzan—are being maintained in a persistent vegetative state in the United States today, and the number will increase significantly in the near future.[1] These patients are the unfortunate product of advances in medical technology over the past 20 years. Increased use of various therapeutic measures such as cardiopulmonary resuscitation, which until recently were either unknown

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[1] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, Hastings Ctr. Rep., Feb./March 1988, at 27, 31.

or not widely practiced, represents an important medical advance. Through these techniques, patients who suffer a cessation of respiratory and perhaps cardiac function can, at times, be restored to physical life. Many such patients are rescued from the brink of death and restored to a meaningful life. But PVS patients cannot be restored. While not brain-dead, PVS patients have sustained massive and permanent brain damage and a complete loss of consciousness from which there can be no recovery. The persistent vegetative state is the most complete and severe form of neurologic disability.

PVS patients are totally and permanently unconscious and devoid of thought, emotion, and sensation. The Academy defines the persistent vegetative state as "a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiological sleep/wake cycles," but in which the patient is at all times totally unaware of herself or her environment. Academy Statement § I. (App. A at 1a). This condition results when a person suffers severe damage to the cerebral hemispheres of the brain, which control the "higher 'thinking' functions," but retains a normal brain stem, which controls reflexive functions. *See* President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 175 (U.S. Govt. Printing Office 1983) (hereinafter "President's Commission"). Thus, PVS patients exposed to certain stimuli may exhibit reflexive responses including grimacing, swallowing, unfocused eye movement, and pupillary response to light. *Id.* However, the loss of all cerebral cortical functions means that "[p]ersonality, memory, purposive action, social interaction, sentience, thought, and even emotional states are gone . . . as are joy, satisfaction, and pleasure." *Id.* at 174-75, 181-82.

Because PVS patients retain a healthy brain stem, they generally do not lose their capacity to breathe, a reflexive function. But they do lose their ability to chew and swallow in a normal manner, a cognitive function. Academy Statement § I.A. (App. A at 1a). Accordingly, a

respirator is generally not needed for life support of PVS patients, but artificial nutrition and hydration are necessary.

The attempt of the majority below to characterize the ongoing provision of nutrition and hydration through a gastrostomy tube as routine care and not medical treatment is not supported by legal, medical, or ethical precedent and contradicts practical medical reality. The tube must be implanted surgically with prior, written consent for the procedure. After surgery, the patient receives a pre-mixed solution of nutrients pumped into the body through a machine. Although nurses perform the relatively uncomplicated procedure of administering the solution, the life support process requires continual and careful monitoring by a physician.[2] All learned medical and medico-ethical organizations agree that provision of nutrition and hydration through such a tube is a medical

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[2] The majority refused to recognize that use of a gastrostomy tube constitutes medical treatment, but noted the finding in *Quinlan* that Karen Quinlan's respirator was medical "treatment . . . so extraordinary and so invasive that the state's interest paled in comparison." *Cruzan v. Harmon*, Petitioner's Appendix at A30 (citing *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976)). But the medical community finds no basis for distinguishing between a respirator and a gastrostomy tube in terms of their status as medical treatment. In each case, as a result of an accident or other trauma, the body loses the ability to perform certain functions on its own and a machine takes over. If a patient cannot breathe, air is pumped in through a respirator; if a patient cannot swallow, fluids and nutrition are pumped in through a surgically implanted tube. Both devices replace normal bodily functions which are compromised by the illness. Both are medical treatment.

The majority's attempt to draw a distinction between initial insertion of the tube (which it considered medical treatment) and the ongoing use of the tube (which it described as "not heroically invasive") is also insupportable. Pet. App. at A34. The power to consent to treatment necessarily must include the power to order the treatment stopped once it has proved ineffective. *See* President's Commission at 73-77; Academy Statement § IV.B.-C. (App. A at 6a-7a).

treatment that a patient has a right to forgo.[3] Likewise, most higher courts that have considered the status of artificial nutrition and hydration have determined them to be medical treatment. *See, e.g., McConnell v. Beverly Enters.-Conn., Inc.*, 209 Conn. 692, 705, 553 A.2d 596, 603 (1989) ("[t]he applicable case law has by and large concluded that . . . there is no logical distinction between removal of a respirator and removal of a gastrostomy tube") (citing cases). The majority's contrary conclusion below is both opposed to established medical practice and offensive to good medical ethics.

Also erroneous is the attempt of the Attorney General of Missouri to characterize the questions surrounding forced continued provision of artificial nutrition and hydration to PVS patients as "extremely narrow" and of little public importance. Brief in Opposition of Respondents Harmon and Lamkins at 12, 16. In fact, proper treatment—including the use of artificial nutrition and hydration—for PVS patients has grown into a medical problem of national significance. This is apparent, not only from the Academy's Statement, but also from the attention given to the matter by a Presidential Commission, the Office of Technology Assessment of the Congress, the American Medical Association, and bio-ethicists as cited in note 3 above.

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[3] Academy Statement §§ II., III. (App. A at 2a-6a); President's Commission at 190; American Medical Association, *Withholding or Withdrawing Life-Sustaining Medical Treatment*, Current Opinions of the Council on Ethical and Judicial Affairs, Opinion 2.18 (1986) (hereinafter "AMA Opinion 2.18") ("[l]ife prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration"); Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 59-62 (1987); U.S. Congress, Office of Technology Assessment, Life-Sustaining Technologies and the Elderly, OTA-BA-306 at 275-329 (U.S. Govt. Printing Office 1987).

B. The *Cruzan* Majority's Ruling Requires the Perpetual Maintenance of Artificial Life Support for PVS Patients Who, by Definition, Have No Hope of Recovery

PVS patients are incapable of feeling pain or otherwise suffering because such sensations are attributes of consciousness requiring cerebral cortical functioning that these patients lack. Academy Statement § I.D. (App. A at 2a). Given this aspect of the persistent vegetative state, the Missouri Supreme Court's interpretation and application of the right to refuse medical treatment *precludes entirely* the withdrawal of artificial nutrition and hydration from a PVS patient until death occurs from other causes

The majority below grudgingly conceded that a federal, privacy-based right to refuse treatment might exist.[4] It then purported to balance the individual's interest in exercising this right against the state's asserted abstract interest in the preservation of all biological life, even if devoid of human consciousness. The majority concluded that the state's interest will always supersede the individual's rights unless (if ever) continued treatment is painful or imposes some other burden on the patient. Finding that the continued supply of nutrients and fluids through a tube surgically implanted in Nancy Cruzan's stomach did not impose any burden on her, the majority held that the state's interest prevailed and artificial life support must continue.[5]

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[4] Pet. App. at A21-A25. The majority also recognized a qualified common law right to refuse treatment grounded in the doctrine of informed consent, and it included that right among the interests of the patient that it weighed against those of the state. *Id.* at A20-A21, A25, A29.

[5] *See Cruzan*, Pet. App. at A36-A37 (central issue "is whether feeding and providing liquid to Nancy is a burden *to her*") (emphasis in original); *id.* at A38 ("[g]iven the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment . . . outweighs the [state's interest in preserving her life]").

As applied to PVS patients, the majority's "balancing" process is a meaningless exercise. As explained above, continued medical treatment of *any* kind can *never* be painful or physically burdensome to a PVS patient because she lacks the cognitive capacity to experience such sensations. Hence, the *Cruzan* majority's reasoning dictates that artificial life support, once initiated for a PVS patient, must be continued indefinitely in all cases. Such support may be discontinued only when some other physiological breakdown occurs—perhaps only after many years—that neither the support system in place nor other medical procedures can remedy.[6]

C. The Irrevocability of an Initial Decision to Employ Artificial Life-Support Technologies Will Discourage Their Use in the First Instance, Thus Endangering Patients' Lives and Violating Accepted Principles of Medical Ethics

Until an unconscious patient is reliably diagnosed as being in a persistent vegetative state, the prognosis for recovery of cerebral cortical functions is uncertain. The diagnosis of PVS usually cannot be made with medical certainty "until the patient's complete unconsciousness has lasted a prolonged period—usually one to three months . . . ." Academy Statement § IV.A. (App. A at 6a). A physician's ethical duty aggressively to seek to cure patients while there is still hope of recovery dictates that a physician treating an unconscious patient urge the patient to accept (through her family or legal representative) artificial life support. Artificial life support measures, including gastrostomy feeding tubes, ensure that the patient will benefit from any spontaneous recovery of consciousness or from successful medical treatment. At present such advice is ordinarily followed.

[6] There was medical testimony in the trial court that Nancy, who was then only 30 years old, could exist as long as 30 years in the same vegetative state if the artificial nutrition and hydration were continued. Pet. App. at A8, A26, A38.

But such advice is much less likely to be either given or heeded if, as the *Cruzan* majority's holding requires, the initial decision to employ artificial life support is irrevocable. Because of an understandable desire to avoid the considerable risk that such authorization will condemn the patient to years of PVS status, physicians will hesitate to advise, and families will be much less likely to authorize, artificial nutrition and hydration for patients whose prognosis is grim but not hopeless. As one court stated, "[s]uch a rule [of irrevocability] could discourage families and even doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die." *In re Conroy*, 98 N.J. 321, 370, 486 A.2d 1209, 1234 (1985).[7] Thus, the *Cruzan* majority's rule not only would discourage the practice of ethical medicine,[8] but ultimately would undermine the state's asserted interest in preserving life.[9]

[7] *See also Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 438, 497 N.E.2d 626, 638 (1986); Lynn & Childress, *Must Patients Always Be Given Food and Water?*, Hastings Ctr. Rep., Oct. 1983, at 17, 19-20.

[8] Numerous state courts have relied on principles of medical ethics to guide them in cases concerning PVS patients. *See Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (Ariz. 1987) (en banc); *In re Gardner*, 534 A.2d 947, 954 (Me. 1987); *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638; *In re Jobes*, 108 N.J. 394, 417, 529 A.2d 434, 446 (1987); *In re Peter*, 108 N.J. 365, 381-82, 529 A.2d 419, 427-28 (1987); *In re Farrell*, 108 N.J. 335, 350-51, 529 A.2d 404, 411-12 (1987); *In re Guardianship of Grant*, 109 Wash. 2d 545, 554-55, 747 P.2d 445, 450 (1987) (en banc); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1141, 225 Cal. Rptr. 297, 303-04 (1986).

[9] It may be possible to interpret *Cruzan* so as to avoid this result, but doing so would create an even worse nightmare. The state might attempt to preclude doctors and families from taking irrevocability into account during early treatment decisions by compelling them to employ all available means of artificial life support in the first instance.

Given the majority's conclusion that the state's interest always outweighs the patient's rights where treatment imposes no burden

D. The Requirement That Physicians Provide Useless and Unwanted Medical Treatment to PVS Patients Is Fundamentally at Odds Both With Principles of Medical Ethics and With an Accurate Assessment of the Benefits and Burdens of Such Treatment

A physician's duty aggressively to promote the well-being of a patient presumes that some chance of improvement or recovery remains. However, the *Cruzan* majority held that artificial life support must be maintained even after hope is lost, apparently on the assumption that physicians still have a duty to "care": "[W]hen we permit ourselves to think that care is useless if it preserves the life of the embodied human being without restoring cognitive capacity, we fall victim to the old delusion that we have failed if we cannot *cure* and that there is, then, little point to continue *care*." Pet. App. at A36 (citation omitted) (emphasis in original).

In the context of a PVS patient's existence, "care" may have symbolic meaning for the caregiver, the family, and society, but it has no meaning for the patient. The patient cannot understand or even perceive her care, much less be comforted by it. Therefore, she cannot be regarded as benefitting from care in any meaningful sense. Hence, ethical principles recognize that where the family,

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(of the sort recognized by the majority), the majority's reasoning usually would sustain such state compulsion. However, the result—forced irrevocable artificial support for all patients under all circumstances—is clearly incompatible with the principle of bodily integrity inherent in the Fourteenth Amendment. *Cf., e.g., Winston v. Lee*, 470 U.S. 753, 761 (1985) (state cannot compel criminal defendant to undergo surgery to retrieve bullet necessary for state's prosecution because of "intrusion upon the individual's dignitary interests in personal privacy and bodily integrity"); *id.* at 765 (surgery absent patient's informed consent is demeaning and intrusive); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.) (recognizing the "right to determine what should be done with [one's] own body"), *overruled on other grounds, Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

speaking for the patient, feels that "care" has become a euphemism for the meaningless prolongation of vegetative life, the physician has no contrary duty to maintain such care. Academy Statement §§ II.A., III. (App. A at 2a-5a); AMA Opinion 2.18.

Moreover, a physician's ethical duty is not to preserve life or well-being at all costs, but rather to do so in a manner consistent with the patient's right to self-determination. *See* Academy Statement § II.D.1. (App. A at 4a) ("The recognition of a patient's right to self-determination is central to the medical, ethical, and legal principles relevant to medical treatment decisions."). Hence, state-compelled maintenance of useless and undesired artificial life support for PVS patients not only directly infringes the patient's constitutional guarantee of fundamental liberty, but it does so in a manner that interferes with physicians' ethical responsibility to avoid harming the dignity of their patients. The *Cruzan* majority ignored the established principle of medical ethics that, "[a]t all times, the dignity of the patient should be maintained."[10] In the process, it withheld from Nancy Cruzan a core aspect of humanity by requiring her and many others sharing her misfortune to be kept "alive" for years to come in an undignified vegetative state.[11] As another high state court realized,

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[10] AMA Opinion 2.18. Furthermore,

> [i]n deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his behalf, the physician should determine what the possibility is for extending life *under humane and comfortable conditions* and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Id. (emphasis added).

[11] As recounted in the Petition for Certiorari, Nancy Cruzan

> is completely dependent upon others for care. Her body is stiff and so severely contracted that her fingernails cut into her

> In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve. . . . The duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.

Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 434, 497 N.E.2d 626, 635 (1986).

By insisting on the preservation of life at all costs and regardless of circumstances, the decision below prevents physicians from taking into account patients', their families', and society's interests in maintaining dignity. It thus precludes physicians from "caring" for their PVS patients in the only way that "care" has any meaning once the PVS diagnosis has been confirmed.

CONCLUSION

For the foregoing reasons, and for those stated in the Petition for a Writ of Certiorari, the Petition should be granted.

Respectfully submitted,

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wrists. Her face is red, puffy and swollen, and she drools on herself. She is missing teeth. Her bathing, oral care and personal feminine hygiene, including menses, are cared for by others. She must be turned every few hours to prevent bedsores.

Petition for Writ of Certiorari at 5 (citation omitted).

APPENDIX

APPENDIX A

POSITION OF THE AMERICAN ACADEMY OF NEUROLOGY ON CERTAIN ASPECTS OF THE CARE AND MANAGEMENT OF THE PERSISTENT VEGETATIVE STATE PATIENT *

Adopted by the Executive Board,
American Academy of Neurology,
April 21, 1988, Cincinnati, Ohio

I. The persistent vegetative state is a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiological sleep/wake cycles, but at no time is the patient aware of him- or herself or the environment. Neurologically, being awake but unaware is the result of a functioning brainstem and the total loss of cerebral cortical functioning.

A. No voluntary action or behavior of any kind is present. Primitive reflexes and vegetative functions that may be present are either controlled by the brainstem or are so elemental that they require no brain regulation at all.

Although the persistent vegetative state patient is generally able to breathe spontaneously because of the intact brainstem, the capacity to chew and swallow in a normal manner is lost because these functions are voluntary, requiring intact cerebral hemispheres.

B. The primary basis for the diagnosis of persistent vegetative state is the careful and extended clinical observation of the patient, supported by laboratory studies. Persistent vegetative state patients will show no behavioral response whatsoever over an extended period of

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* Reprinted in Neurology, Jan. 1989, at 125.

time. The diagnosis of permanent unconsciousness can usually be made with a high degree of medical certainty in cases of hypoxic-ischemic encephalopathy after a period of 1 to 3 months.

C. Patients in a persistent vegetative state may continue to survive for a prolonged period of time ("prolonged survival") as long as the artificial provision of nutrition and fluids is continued. These patients are not "terminally ill."

D. Persistent vegetative state patients do not have the capacity to experience pain or suffering. Pain and suffering are attributes of consciousness requiring cerebral cortical functioning, and patients who are permanently and completely unconscious cannot experience these symptoms.

There are several independent bases for the neurological conclusion that persistent vegetative state patients do not experience pain or suffering.

First, direct clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering.

Second, in all persistent vegetative state patients studied to date, postmortem examination reveals overwhelming bilateral damage to the cerebral hemispheres to a degree incompatible with consciousness or the capacity to experience pain or suffering.

Third, recent data utilizing positron emission tomography indicates that the metabolic rate for glucose in the cerebral cortex is greatly reduced in persistent vegetative state patients, to a degree incompatible with consciousness.

II. The artificial provision of nutrition and hydration is a form of medical treatment and may be discontinued in accordance with the principles and practices governing the withholding and withdrawal of other forms of medical treatment.

A. The Academy recognizes that the decision to discontinue the artificial provision of fluid and nutrition may have special symbolic and emotional significance for the parties involved and for society. Nevertheless, the decision to discontinue this type of treatment should be made in the same manner as other medical decisions, i.e., based on a careful evaluation of the patient's diagnosis and prognosis, the prospective benefits and burdens of the treatment, and the stated preferences of the patient and family.

B. The artificial provision of nutrition and hydration is analogous to other forms of life-sustaining treatment, such as the use of the respirator. When a patient is unconscious, both a respirator and an artificial feeding device serve to support or replace normal bodily functions that are compromised as a result of the patient's illness.

C. The administration of fluids and nutrition by medical means, such as a G-tube, is a medical procedure, rather than a nursing procedure, for several reasons.

1. First, the choice of this method of providing fluid and nutrients requires a careful medical judgment as to the relative advantages and disadvantages of this treatment. Second, the use of a G-tube is possible only by the creation of a stoma in the abdominal wall, which is unquestionably a medical or surgical procedure. Third, once the G-tube is in place, it must be carefully monitored by physicians, or other health care personnel working under the direction of physicians, to insure that complications do not arise. Fourth, a physician's judgment is necessary to monitor the patient's tolerance of any response to the nutrients that are provided by means of the G-tube.

2. The fact that the placement of nutrients into the tube is itself a relatively simple process, and that the

feeding does not require sophisticated mechanical equipment, does not mean that the provision of fluids and nutrition in this manner is a nursing rather than a medical procedure. Indeed, many forms of medical treatment, including, for example, chemotherapy or insulin treatments, involve a simple self-administration of prescription drugs by the patient. Yet such treatments are clearly medical and their initiation and monitoring require careful medical attention.

D. In caring for hopelessly ill and dying patients, physicians must often assess the level of medical treatment appropriate to the specific circumstances of each case.

1. The recognition of a patient's right to self-determination is central to the medical, ethical, and legal principles relevant to medical treatment decisions.

2. In conjunction with respecting a patient's right to self-determination, a physician must also attempt to promote the patient's well-being, either by relieving suffering or addressing or reversing a pathological process. Where medical treatment fails to promote a patient's well-being, there is no longer an ethical obligation to provide it.

3. Treatments that provide no benefit to the patient or the family may be discontinued. Medical treatment that offers some hope for recovery should be distinguished from treatment that merely prolongs or suspends the dying process without providing any possible cure. Medical treatment, including the medical provision of artificial nutrition and hydration, provides no benefit to patients in a persistent vegetative state, once the diagnosis has been established to a high degree of medical certainty.

III. When a patient has been reliably diagnosed as being in a persistent vegetative state, and when it is clear that the patient would not want further medical

treatment, and the family agrees with the patient, all further medical treatment, including the artificial provision of nutrition and hydration, may be forgone.

A. The Academy believes that this standard is consistent with prevailing medical, ethical, and legal principles, and more specifically with the formal resolution passed on March 15, 1986 by the Council on Ethical and Judicial Affairs of the American Medical Association, entitled "Withholding or Withdrawing Life-Prolonging Medical Treatment."

B. This position is consistent with the medical community's clear support for the principle that persistent vegetative state patients need not be sustained indefinitely by means of medical treatment.

While the moral and ethical views of health care providers deserve recognition, they are in general secondary to the patient's and family's continuing right to grant or to refuse consent for life-sustaining treatment.

C. When the attending physician disagrees with the decision to withhold all further medical treatment, such as artificial nutrition and hydration, and feels that such a course of action is morally objectionable, the physician, under normal circumstances, should not be forced to act against his or her conscience or perceived understanding of prevailing medical standards.

In such situations, every attempt to reconcile differences should be made, including adequate communication among all principal parties and referral to an ethics committee where applicable.

If no consensus can be reached and there appear to be irreconcilable differences, the health care provider has an obligation to bring to the attention of the family the fact that the patient may be transferred to the care of another physician in the same facility or to a different facility where treatment may be discontinued.

D. The Academy encourages health care providers to establish internal consultative procedures, such as ethics committees or other means, to offer guidance in cases of apparent irreconcilable differences. In May 1985, the Academy formally endorsed the voluntary formation of multidisciplinary institutional ethics committees to function as educational, policy-making, and advisory bodies to address ethical dilemmas arising within health care institutions.

IV. It is good medical practice to initiate the artificial provision of fluids and nutrition when the patient's prognosis is uncertain, and to allow for the termination of treatment at a later date when the patient's condition becomes hopeless.

A. A certain amount of time is required before the diagnosis of persistent vegetative state can be made with a high degree of medical certainty. It is not until the patient's complete unconsciousness has lasted a prolonged period—usually 1 to 3 months—that the condition can be reliably considered permanent. During the initial period of assessment and evaluation, it is usually appropriate to provide aggressive medical treatment to sustain the patient.

Even after it may be clear to the medical professionals that a patient will not regain consciousness, it may still take a period of time before the family is able to accept the patient's prognosis. Once the family has had sufficient time to accept the permanence of the patient's condition, the family may then be ready to terminate whatever life-sustaining treatments are being provided.

B. The view that there is a major medical or ethical distinction between the withholding and withdrawal of medical treatment belies common sense and good medical practice, and is inconsistent with prevailing medical, ethical, and legal principles.

C. Given the importance of an adequate trial period of observation and therapy for unconscious patients, a family member must retain the ability to withdraw consent for continued artificial feedings well after initial consent has been provided. Otherwise, consent will have been sought for a permanent course of treatment before the hopelessness of the patient's condition has been determined by the attending physician and is fully appreciated by the family.